

SUPPORT FOR THE PAIN RELIEF
PROMOTION ACT**HON. JAMES A. BARCIA**

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Monday, October 25, 1999

Mr. BARCIA. Mr. Speaker, my esteemed colleague from Oregon, Mr. BLUMENAUER, recently presented remarks on the floor to defend Oregon's assisted suicide policy and to criticize the proposed Pain Relief Promotion Act, H.R. 2260.

First of all, I think it is important to clarify the fact that H.R. 2260, the Pain Relief Promotion Act, does not limit states' ability to legislate assisted suicide. It simply clarifies that assisted suicide may not take place with federally controlled substances. This allows states to pass their own laws while clarifying the boundaries of federal involvement regarding assisted suicide. This bill also does not establish any new authority to penalize assisted suicide. My colleague has every right to speak in favor of the policy his constituents have chosen. But by the same token, representatives of the other 49 states that have chosen not to follow such a policy have a right to ask: Why should we be voiceless participants in Oregon's experiment with assisted suicide?

Mr. BLUMENAUER has expressed grave concern over the provision in the bill that makes it illegal to intentionally prescribe federally controlled drugs with the intent to cause a patient's death. Under this provision, he says, law enforcement personnel will be judging, for the first time, whether a doctor's "intent" is to cause a patient's death. I would like to take the time right now to respond to this objection.

Currently, the Drug Enforcement Administration (DEA) routinely makes these judgments. They have always had the right to revoke controlled substance permits based on abuse by health care workers. Whenever a prescription is written for a federally controlled substance, a DEA prescription is printed using a federal DEA registration number which is then attached to the actual bottle of pills. In this way, the DEA can keep record of and check whether or not federally controlled drugs are being used for "legitimate medical purposes." There are numerous instances in which physicians have had their DEA registrations suspended or revoked because they used these drugs in ways that led to patients' deaths by drug overdose. Clearly then, the DEA has the authority, right and experience to do what it has always been doing—monitor the use of federally controlled substances. Even more extensive federal involvement, though, has been prompted by Oregon's assisted suicide law. It is my colleague's own state legislature, in fact, that has escalated federal involvement by enacting a law that freely uses federally controlled substances for assisted suicides. In so doing, Oregon has practically demanded, perhaps unintentionally, that the federal government review and clarify its policy regarding what constitutes a "legitimate medical purpose." The federal government obviously has a right to say how federally controlled substances can be used. And so it is the aim of H.R. 2260 to address this question by clarifying the federal government's policy on the use of federally controlled substances in relation to assisted suicides.

Department of Justice policy currently forces the federal government to implicitly endorse

assisted suicide by directing the DEA to allow federally controlled substances to be used in any manner which a state's assisted suicide law may prescribe. Every time a lethal overdose of barbiturates is prescribed to assist an Oregon citizen's suicide, the federal authority of the DEA is invoked to authorize the prescription. Since the Controlled Substances Act requires that such prescriptions be used for a "legitimate medical purpose," the federal government implicitly endorses the use of federally controlled substances in each case of assisted suicide as a "legitimate medical purpose" under current Justice Department Policy. It is only appropriate then, that we clarify how federally controlled substances can be used instead of letting an individual state that is heroically experimenting with democracy dictate how these federally controlled substances will be used. After all, they are federally controlled substances and they require federal control.

H.R. 2260 clarifies that assisted suicide will not be performed with the federal government's blessing. It also ensures that enforcement of the Controlled Substances Act will distinguish between intentional killing and the unintended hastening of death that may rarely occur as a side-effect of aggressive pain control. (This particular distinction, by the way, is found explicitly in almost all state laws against assisted suicide enacted in recent years; it was upheld as a reasonable and workable legal standard by the U.S. Supreme Court in its *Vacco v. Quill* decision two years ago.) Finally, H.R. 2260 provides the funds needed to begin to seriously advance our understanding of pain management.

Beginning with the premise that aggressive pain control is to be encouraged as a legitimate part of modern medical practice, the legislation backs up this declaration through \$5 million per year for the training of health professionals in palliative care, and for the education of law enforcement personnel so that they will be sensitive to the legitimate needs of modern pain management when they perform their necessary task of preventing misuse. Because this legislation sends such a clear and positive message about pain management to physicians and patients, it has been endorsed by organizations that both deal with pain issues on a regular basis and are in a position to judge the merits of the legislation. Among a notable list of supporters are the American Medical Association, the National Hospice Organization, the Hospice Association of America and the American Academy of Pain Management.

In the end, the federal government, in concert with groups that understand and are active practitioners of pain management, must make a policy decision regarding the appropriate use of drugs that fall within its jurisdiction. Will they be used to kill pain or kill patients? I believe H.R. 2260 makes the right choice.

NATIONAL CHILDHOOD LEAD
POISONING PREVENTION WEEK**HON. CARRIE P. MEEK**

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Monday, October 25, 1999

Mrs. MEEK of Florida. Mr. Speaker, last week the Senate passed, by unanimous con-

sent, a resolution which designates this week—October 24, 1999, through October 30, 1999—and a similar week next year as "National Childhood Lead Poisoning Prevention Week." I would like to take this opportunity to inform my colleagues about the very serious problem of childhood lead poisoning.

Lead poisoning is a leading environmental health hazard to children in the United States. According to the United States Center for Disease Control and Prevention, 890,000 preschool children in the United States have harmful levels of lead in their blood which can cause serious, long-term harm to children, including reduced intelligence and attention span, behavior problems, learning disabilities, and impaired growth. Children from low-income families are 8 times more likely to be poisoned by lead than those from high income families.

Mr. Speaker, I have worked with the Alliance to End Childhood Lead Poisoning and other concerned groups to help address this problem. I would like to submit the following article from the American Journal of Public Health which further details the lead poisoning problem and strategies to combat it.

[From the American Journal of Public Health, June 1999]

PROTECTING CHILDREN FROM LEAD POISONING
AND BUILDING HEALTHY COMMUNITIES

Lead's toxicity to human organs and systems has been extensively documented for over 2 millennia. The 20th century is remarkable for the dispersal of lead throughout the human environment, making lead poisoning a community health problem of global dimensions.¹ Young children are at highest risk because of lead's neurotoxic effects, which reduce intelligence and attention span and cause learning difficulties and behavior problems.^{2,3} Blood lead screening and surveillance are important tools, but primary prevention requires controlling sources of exposure. Although the challenge varies from country to country, the steps needed to eliminate this disease are now apparent.

EVIDENCE THAT ENVIRONMENTAL CONTROLS
WORK

Over the past quarter century, progress on childhood lead poisoning in the United States has been remarkable: the mean blood lead level of US children fell by 80%, and the number of children with elevated blood leads declined by 90%.^{4,5} These changes did not occur spontaneously or by chance. Strict regulation of many lead uses, enacted after decades of determined industry opposition, has gradually detoxified the air, water, and food supply. The evidence is clear that controlling ongoing sources of lead exposure produces immediate and significant health benefits, which typically far outweigh the costs.⁶ The difficulty of cleaning up once lead contaminates the environment underscores the urgency of controlling it at the source.

THE LEGACY OF LEAD-BASED PAINT

Despite impressive progress, lead poisoning remains a serious environmental health hazard in the United States: 4.4% of all children aged 1 to 5 years have elevated blood lead levels ($\geq 10 \mu\text{g/dL}$).⁵ Lead-based paint in nearly two thirds of all U.S. housing poses by far the greatest remaining challenge.⁷ (In particular communities and populations, a variety of other sources and pathways also expose children to lead.) While children can be severely poisoned by eating paint chips, the principal pathway is chronic exposure to settled lead dust, which gets on children's

hands and toys and is ingested through normal hand-to-mouth behavior.⁸ Recent research has confirmed the important role of interior lead dust and the need for more protective standards.⁹

Two distinct scenarios account for most lead poisoning in U.S. children: paint deterioration because of poor maintenance and remodeling projects that inadvertently release lead particles. Remodeling and repainting projects that fail to control and clean up lead dust likely account for 5% to 10% of poisonings,¹⁰ a challenge that conventional health education and limited training can overcome. The dominant scenario of poisoning among U.S. children is unattended deteriorating paint and lead dust hazards in older, low-income housing. Water damage and excessive moisture are the principal causes of paint deterioration as well as of a multitude of other health hazards. For example, moisture encourages the growth of mold, mildew, mites, and microbes, which contributes to asthma and other respiratory problems.¹¹

In the 1980s, many considered the presence of leaded paint a health hazard. Paralyzed by the insuperable difficulties of full removal (the cost alone is estimated at \$500 billion),¹² the public health response was confined almost entirely to belatedly reacting to already poisoned children. Despite its appeal at many levels, literally "getting the lead out" of U.S. housing is not a feasible primary prevention strategy. Research has validated the effectiveness of strategies that safely manage leaded paint in place¹³⁻¹⁵ and has shown that poor paint condition is a stronger predictor of risk than the paint's lead content.⁸ Rather than removing lead paint from a few properties, the more effective path to protecting children at risk is to make housing lead safe, a formidable but surmountable public health challenge.

PROTECTING CHILDREN AT RISK REQUIRES NEW APPROACHES

Continuation of current strategies is unlikely to provide near-term protection to children living in low-income housing in distressed communities, who are at highest risk for lead poisoning. Four shifts in approach are required to eradicate childhood lead poisoning in the United States.

Make Lead Safety an Integral Part of Housing Activities

Recognition that poor housing condition is a root cause of lead hazards demands a shift from the traditional approach whereby experts deal with one environmental hazard at a time. Rather than being viewed as the province of a small corps of experts conducting one-time interventions, lead safety in older housing must be integrated into various activities. While "abatement contractors" are needed for complex projects, techniques for controlling moisture and lead dust must be incorporated into all housing activities, remodeling, and vacancy treatments. Basic training in moisture control and lead safety will arm painters, remodelers, maintenance staff with vital skills and can help build indigenous capacity within communities at high risk for lead poisoning. Housing codes must be updated and enforced to ensure control of moisture and lead dust hazards.

Identify and Control Lead Hazards Before Poisoning Occurs

Preventing poisoning requires demystifying the detection of property-specific lead hazards, the vast majority of which have never been identified, much less controlled. While only a certified lead expert can declare a property "safe" for legal purposes,¹⁶ visual inspections for maintenance deficiencies can trigger corrective preventive

measures. Sending a chip of peeling paint or a single "dust wipe" to an environmental laboratory for analysis (about \$5 per sample) is sufficient to detect a hazard in a high-risk property. Because deteriorated paint and dust lead levels on floors and other surfaces are strong predictors of risk, health departments need to screen high-risk housing as well as test children's blood lead levels. Parents, property owners, contractors, and community residents can be trained in a single day to conduct visual maintenance checks and environmental sampling. Environmental samples provide property-specific information that can transform the federal lead-based paint "right-to-know" law from an empty promise to a catalyst for action.¹⁷

Secure New Resources for Prevention

Both the public and private sectors need to dedicate additional resources to controlling housing-related health hazards. The lead, petroleum, and paint industries need to contribute their share to prevention through either the courts or the Congress. Managed care providers can reduce health care costs for asthma and lead poisoning by making strategic investments to address environmental hazards in housing before children are exposed. In particular, the Medicaid program, which serves children at high risk for lead poisoning,¹⁸ should explore ways to support the early identification and control of health hazards in high-risk housing. Medicaid must also start screening all young children as required¹⁹ and provide the recommended follow-up services.²⁰ Government support for affordable housing should be increased to recognize the importance of decent housing in controlling environmental health hazards and reducing health care and education costs.

Make Healthful Housing a National Environmental Priority

Protecting at-risk children from lead hazards in their homes requires reintegrating housing into public health and environmental health practice. The environmental and public health communities and those who fund their research, advocacy, and policy work must begin to shift attention from the ambient environment to confront the reality that substandard housing in distressed communities is the leading environmental health threat to U.S. children. There is no more chilling example of environmental injustice than concentrations of substandard housing in low-income urban neighborhoods, reflected by the fact that low-income children and Black children are at 8 times and 5 times higher risk for lead poisoning, respectively, than other U.S. children.⁵ Without leadership by the environmental, public health, medical, and philanthropic communities, the accelerating deterioration of housing in distressed communities will increasingly threaten health, spread blight, and devastate low-income families.

THE GLOBAL CHALLENGE

The causes of lead poisoning vary country by country and community by community.²¹ Because significant sources of lead exposure remain largely unregulated in most countries, both developed and developing, lead poisoning is typically more widespread and severe in other countries than in the United States.

A common excuse for delaying control at the source is the perceived need to determine the exact extent of the problem and the specific contribution of each source. Environmental and health officials must not allow industry's demands for screening, surveillance, or epidemiological studies to preempt or postpone the control of obvious and serious sources of exposure. Where dispersive uses of lead continue, the self-evidence of

both the problem and the remedy demands action. The ready availability of superior, practicable alternatives makes the continued use of lead inexcusable in any product with the potential for broad exposure (e.g., gasoline, paint, plumbing supplies, food cans, printing ink, fertilizer, and children's toys).

Leaded gasoline, the foremost cause of global lead exposure, is the obvious first candidate for control in the more than 150 countries in which it is still in use.²² All automobile engines can operate on unleaded gasoline,²³ and superior, cost-competitive alternatives are readily available to replace lead or reduce engine octane demand.²⁴ Removing lead from gasoline is the single greatest step to preventing lead poisoning as well as a prerequisite to achieving other air quality improvements through the introduction of catalytic converters and modern engine technology.²⁵ There is no excuse for leaded gasoline use to continue in any country after the end of this century.

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